Commonwealth of Massachusetts
Executive Office of Health and Human Services
www.mass.gov/dhcfp

Pharmacy 90-Day Waiver Form

Use this form to request a 90-day waiver for one of the reasons indicated in the Explanation box below. All fields must be completed to process the request.

Pharmacy information

(Required to receive approval notification)

Date	Pharmacy name	Provider number	Fax number	Location code

Health Safety Net (HSN) Patient Information

Last name	First name	Date of birth (mmddyyyy)	Gender f m	ID #
Address		**City**	**State**	**ZIP**

Claim Information

	Manufacturer	Item	Pkg.	Drug name		Quantity	Days' supply
1							
	Prescriber's NPI	Date written	Date filled	Prescription no.	Usual charge	Other pd. amount	Prior auth. no.
2							
3							
4							

Explanation: Please indicate the reason for the 90-day waiver below.

- ☐ Rebilling a previously denied timely filed claim (attach remittance advice)
- ☐ Retroactive member enrollment (attach proof)
- ☐ Retroactive provider enrollment (attach proof)

Please fax the completed form to ACS State Healthcare at 1-866-556-9315